Recovery audit contractors: Learn from your peers

JUNE 3, 2008 —

Recovery audit contractors: Learn from your peers

As your HIM department prepares for the national expansion of the Recovery Audit Contractor (RAC) program in 2010, there is no better source of advice than hospitals in states where RACs are already present.

HIM directors from California, New York, and Florida shared their implementation perspectives at a roundtable discussion during HCPro's March 11 audioconference, "Recovery Audit Contractors: Lessons Learned to Help Your Hospital Prepare Now." The speakers included:

- **Kathy Johnson,** director of coding services at Care Communications, Inc., in Chicago (moderator)
- **Allison Bloom, MBA, RHIA,** director of HIM at New York University (NYU) Medical Center in New York City, which consists of of Tisch Hospital, Rusk Institute of Rehabilitation Medicine, and NYU Hospital for Joint Diseases (a total of 1,116 inpatient beds) as well as the NYU Clinical Cancer Center
- **Denise Morris, RHIA,** DRG coordinator at Sarasota (FL) Memorial Health Care System, an 862-bed acute care hospital with a psychiatric facility and a comprehensive rehabilitation facility, in addition to several other outpatient facilities
- **Adriana van der Graaf, MBA, RHIA, CHP, CCS,** revenue cycle administrator at the Community Memorial Health System of San Buenaventura, CA, a 250-bed acute care hospital

Background

The RAC demonstration program began in 2005 and initially involved only three states. As of 2007, the RAC demonstration program expanded to include 22 states. By 2010, CMS plans to have four contractor regions in place, each of which will have its own RAC that will be responsible for identifying over- and underpayments in approximately one-quarter of the country each.

For more information on the RAC timeline, including when RACs are scheduled to go live in your state, visit www.cms.hhs.gov/RAC/Downloads/RAC%20Expansion%20Schedule%20Web.pdf.

A summary of pertinent information from the discussion follows.

Overall RAC experience

KJ: Can you describe your experiences with RACs thus far?

AV: We've found that the RAC would look at one particular DRG, and when it exhausted that DRG, it would move to another. It was difficult in terms of managing staffing because the number of requests was not predictable from month to month.

DM: We also could not predict what the RAC would request because we would go weeks without receiving any requests, and then we would be inundated with several packets of requests. Overall, they've requested more than 5,500 records since the demonstration project began.

AB: [Tisch Hospital] has really been unscathed by much of the RAC activity, whereas we've seen a lot more activity in our rehabilitation hospital and somewhat in our cancer center. The NYU Hospital for Joint Diseases has certainly seen the most RAC activity out of all of our facilities.

The RAC team

KJ: Who have you involved in your RAC team?

AB: Your team will depend on the size and complexity of your organization. It should certainly include HIM because they're going to be the ones who are coordinating the requests for records. Patient financial services is an important part of the team, as well as quality assurance for helping with internal processes and reviews. Senior leadership has to be on board, and you need to ensure that your hospital's reimbursement department is setting aside sufficient reserves for potential recoupments.

AV: I agree with Allison, but I also wanted to point out that each member must understand the time that is involved in responding to requests. When RACs began to look at medical necessity and our case managers became involved in the process, we struggled with stressing the fact that we needed in-depth response letters from them. Involving case managers and other providers requires much time and many resources. Draft policies/procedures and flow charts as early as possible. We also created a centralized Internet location where we could scan letters, follow-up information, and anything else that we needed to communicate to a group of people.

RACs and case management

KJ: How have RACs affected your case management department?

AV: Case management is the group that you need to engage very early. In total, it took almost half of a full-time equivalent in the case management department to draft all of the written letter responses.

DM: I agree that case management really needs to be involved early on. We've learned our lesson, to the extent that one of our physician advisors for our integrated case management department has become involved, and he actually is now performing our medical necessity reviews, writing the appeals letters, and following through.

Centralized vs. decentralized responses

KJ: In terms of staffing structure, are you using a centralized or decentralized model to respond to requests?

AV: We centralized it. We found it's much more useful, and it ensured that we could really track everything. We have designated our coding manager as the RAC contact person. You have to let the RAC know who the contact person is going to be. Sometimes this takes more than one letter or one communication.

AB: We have one centralized coordinator, but the actual processing for each of our three facilities is decentralized. We include all of the RAC team members from all of our facilities in the communications so that everyone is on the same page, but the actual processing for each request is decentralized.

DM: We also have a central person, our compliance officer, who receives all requests. This individual logs them in, and we have one central tracking area so that we know what is going on with each of the requests, whether it is for records, DRG changes, or medical necessity denials. Our chief compliance officer is the RAC contact. So the employees who process the mail in her area are very cognizant of the fact that she must receive all RAC correspondence.

Staff education

KJ: How have you educated staff members with respect to RACs?

DM: I've done some one-on-one training with other departments. Within the coding department, we've been looking back through *Coding Clinic* to ensure that we're meeting criteria. Then we educate physicians regarding the specific documentation needed. We also have a clinical documentation improvement program. It's very helpful to have a coder performing the clinical documentation reviews, as opposed to the nursing staff, because nurses don't quite understand the difference between the clinical and coding aspects, and nurses tend to diagnose because they are accustomed to doing that.

AB: We initially focused our educational efforts on our internal processes and [ensuring] that information was being processed and tracked correctly. We also have worked with our admitting department to ensure that patients meet medical necessity and

that the physicians are admitting appropriately. I do think it's a good point to show the physicians that this is not just a hospital issue, but it is also something that should be important to them because it will affect them in their offices as well.

AV: We educated physicians and attending physicians regarding RAC basics, including what it means for them. We've also had clinical documentation specialists review our inpatient records and assist physicians with documentation to ensure that all information is in the medical record at the time of discharge. That is really making a difference for us. We use mostly coders as clinical documentation specialists, because they are better equipped to explain coding terminology to the medical staff. Using coders as documentation specialists also means that you have fewer turf wars than you might if another clinician serves in that role.

Integration of RAC requests into daily work

KJ: How have you integrated the RAC review process into your routine procedures?

AV: We reallocated work. The coding supervisor, who had been somewhat of a working supervisor, has become less of a working supervisor and has assumed that RAC liaison role. Our case management department also had to reallocate responsibilities to centralize the review for medical necessity. Overall, it meant further tightening procedures to ensure that we're working as efficiently as possible and that the communication is absolutely impeccable.

DM: We were definitely putting in a little bit more effort and sharing some of our other duties that we weren't necessarily sharing before so that everybody was up to speed. If our RAC point person is out, there is always someone there who can serve as the liaison.

AB: We use an electronic tracking system to keep things on time. We run reports each week to ensure that we're watching our deadlines, meeting the turnaround time, and getting the return receipt from the auditors. The ability to provide a timely, accurate, well-coded record is going to be the key to success with the RAC audits.

Note: Consider tracking the following essential pieces of data:

- Date of initial RAC correspondence
- Initial date received
- Recoupment date
- Claim appealed
- RAC denial modified (partial payment)
- RAC denial reversed (full repayment)
- RAC process complete

RACs and productivity

KJ: How have RACs affected productivity?

DM: I would say that it had some impact on our productivity, but not across the board for everybody. Under the demonstration period, RACs requested records back to 2002. This made it extremely difficult for some of us because we had transferred information to a new system, and we had to manually go back and look at microfilm and microfiche. Now, we've implemented an electronic record that is very easy for us to use when accessing information.

AV: Our RACs went back to 2001. It was very time-consuming to research coding rules from so long ago, and we also had an instance in which the RAC was using the wrong set of coding rules. My suggestion would be to keep all of your coding books and documentation, because you will need to refer to them.

Note: To purchase a copy of the audioconference on which this article is based, visit *www.hcmarketplace.com/prod-6222.html*.

Editor's note: This article appeared in the June 2008 issue of ***Medical Records Briefing****.*

Contact Kathy Johnson by e-mailing kjohnson@care-communications.com.

Contact Allison Bloom, MBA, RHIA, by e-mailing allison.bloom@nyumc.org.

Contact Denise Morris, RHIA, by e-mailing denise-morris@smh.com.

*Contact Adriana van der Graaf, MBA, RHIA, CHP, CCS, by e-mailing*avandergraaf@cmhhospital.org.